Reopening vs. Redetermination

Job Aid

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

REOPENINGS

A Reopening is a process used to correct minor errors or omissions to a previously processed claim without using the formal appeals process.

CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors; or,
- Incorrect data items, use of a modifier, or date of service.

A reopening must be requested within one year from the date of the initial determination. The law provides that Reopenings may be done to correct minor errors or omissions that are clerical errors. The contractor has discretion in determining what meets this definition and therefore, what could be corrected through a reopening.

NOTE: Reopening requests received with invalid or inaccurate information cannot be processed and will be returned with a system generated letter.

Inquiries will not be accepted if sent as a Reopening. Examples of "inquiries" include:

- Asking for the status of claims or Reopening requests previously submitted
- Questions regarding denied and/or rejected (Return-to-Provider (RTP)) claims
- Questions on the amount paid on processed claims
- Requests to reprocess previously submitted claims without identifying specific error or changes needed

Inquiries must be handled by the Provider Contact Center. For options, please go to http://cgsmedicare.com/partb/cs/index.html.

TYPES OF REOPENINGS

myCGS Reopenings

Providers who register to use myCGS, our secure, online web portal, may submit Reopening requests electronically to correct minor errors or omissions to claims previously processed. Requests may be submitted for a single beneficiary, multiple beneficiaries and for a single beneficiary with Medicare Secondary Payer (MSP) involved.

The following information must be included on a Medicare Part B myCGS Reopening:

Provider Information:

- Provider's Address
- Provider's Phone Number
- Last 5 digits of Tax Identification Number (TIN)
- National Provider Identifier (NPI)

Beneficiary Information:

- Name
- Patient's Address
- Medicare Health Insurance Claim (HIC) number
- Patient's Phone Number

There are no limits to the number of Reopening requests you may submit. Simply complete the online form in its entirety and attach supporting documentation, if applicable. Up to 5 attachments may be included. All attachments must in a PDF format and no more than 5MBs in size. Providers can also track the status of the Reopening request.

To submit a request for Reopening through myCGS, step-by-step instructions are available in the Part B provider section of Chapter 7 (http://www.cgsmedicare.com/pdf/myCGS/chapter7_partb.pdf) in the *myCGS User Manual*.

NOTE: Allowing Reopening requests to be submitted through myCGS is being offered as a convenience. myCGS Reopenings are processed under the same guidelines as hardcopy requests. In addition, the timeframe to process a Reopening sent via myCGS is no different than a hardcopy request.

When submitting Reopenings please note the following:

- Inquiries will not be processed as Reopenings. Reach out to the Provider Contact Center with inquiries: http://www.cgsmedicare.com/partb/cs/index.html.
- Do not submit duplicate requests.
- Check for accuracy PRIOR TO submitting the form to avoid errors.
- If erroneous Reopenings are submitted, do not resubmit corrections until the initial request is finalized.
- Reopenings may take up to 60 days to process. Do not send "second" and "third" requests.

Telephone Reopenings

A provider can request a telephone reopening of clerical errors or omissions that can be corrected quickly and easily over the telephone. CGS ensures that the Privacy Act of 1974, 5 USC, §552a, is applied to its telephone reopening process. The Telephone Reopening line is available from 8:00 a.m. – 5:00 p.m. (EST). CGS Part B Reopening Telephone number: 1.866.276.9558 (option 4)

Please keep in mind that the telephone reopening representatives assist as many callers as possible each day. When calling, please indicate that you are requesting a telephone reopening. **The following information is needed for verification. All items must match exactly:**

- The Billing provider's/physician's/supplier's name;
- Both the Provider Transaction Access Number (PTAN) and NPI
- Last 5 digits of the TIN

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- Beneficiary's complete name; and
- Medicare HIC number.

The following items shall be obtained/recorded/confirmed during the telephone reopening:

- Date of call;
- Name of caller;
- Phone number of the party;
- Date(s) of service;
- Item(s) or service(s) in question;
- Rationale for not processing the request, if applicable;
- Name of reviewer; and
- Confirmation number, if claim is adjusted.

Written Reopenings

A written reopening is a hard copy request of clerical errors or omissions to be corrected on a Medicare claim. For your convenience, CGS has created the Medicare Part B Reopening Adjustment Request Form (http://www.cgsmedicare.com/forms/reopening_form.pdf). The form should be mailed to:

Attention: Written Adjustments
CGS
PO Box 20018
Nashville, TN 37202

It is important that the form be completed in its entirety and be legible. We suggest completing the form online, then printing to include the signature. Failure to do so may cause the request to be returned with a system generated letter, identifying the request could not be honored at this time. Providers may attach supporting documentation. However, if a CMS-1500 claim form is submitted with the Written Reopening Request Form, the requestor must give specific details of what corrections to make and include the "corrected" CMS-1500 claim form that matches the requested information.

For example, the Written Reopening Request Form may indicate to correct the submitted amount, add a specific modifier, or correct a diagnosis code to a procedure code. However, the new submitted amount, modifier, or diagnosis code is not listed on the attached CMS-1500 "corrected" claim form. This will prompt a letter to be sent back to the provider asking to specify the correction needed.

The following items must be included on the Medicare Part B Reopening form:

- State (in which the service was rendered)
- Date (of completion of the form)
- Provider Information
  - Name
  - PTAN
  - NPI
  - Last 5 digits of TIN
  - Provider's Address
  - Provider's Phone Number
- Beneficiary Information
  - Name
  - Medicare HIC Number
  - Patient's Address
  - Patient's Phone Number
- Service Date
- HCPCS/CPT
- Internal Control Number (ICN) of the claim
- Reason for the Request
- Supporting Documentation
- Completed By/Signature

For your convenience CGS allows providers to submit their Medicare Part B Reopenings Adjustment Request form via fax. Please ensure that you use the fax number applicable for your state:

- **Kentucky** 1.615.664.5914
- **Ohio** 1.615.664.5924

NOTE: Illegible requests will be returned with a system generated letter. When submitting hardcopy requests, we suggest completing the form online, then printing to obtain signatures.

The timeframe to process a Reopening may take up to 60 days. Do not send "second" and "third" requests.

When To Use Telephone Reopenings

The requests handled by the Telephone Reopening include (not an all inclusive listing):

- Adding or changing modifiers (e.g., CPT modifiers 24/25/57/58/78/79/59/76/50)
- Changes in the date of service within the same year (different years have to be handled by Overpayment Recovery)
- Procedure code(s) billed in error and paid if the new code will allow the same or more money
- Submitted amount
- Number of units
- Diagnosis submitted

The following requests *cannot* be handled by Telephone Reopening (not an all inclusive listing):

- Unprocessable Denials (Remark Code **MA-130**/Claims without appeal rights)
- Medicare Secondary Payer Claims
- Reduced services
- Place of Service
- Claims that are more than a year old from the original remit date
- Unlisted procedure codes
- Claims that have demand requests for refund
- Add CPT modifiers 22, 53, 54; and HCPCS modifiers KX and QW
- Adding additional line items that were not already billed
- Requests to recoup money
- Patient's Name/HIC number changes
- Change provider name, PTAN, or NPI for referring, ordering, or performing physician information
- Add notes in block 19 on the CMS-1500 claim form

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- Errors in Medicare processing (claims reduced in error, keyed incorrectly, scanned incorrectly, duplicate in error)
- Upcoding to New Patient Visits, which also includes the Welcome to Medicare Visit (HCPCS code G0402) and the Annual Wellness Visit Codes (HCPCS codes G0438 and G0439)
- Requests from providers who are currently receiving payment adjustments (reductions) as a result of the Electronic Prescribing (eRx), Electronic Health Record (EHR) and/or Physician Quality Reporting System (PQRS) Incentive Programs

When to Use Written Reopenings

- Adding or changing modifiers (e.g., CPT modifiers 24/25/57/58/78/79/59/77/76/50)
- Changes in the date of service within the same year (different years have to be handled by Overpayment Recovery).
- Procedure code(s) billed in error and paid if the new code will allow the same or more money
- Submitted amount*
- Number of units*
- Diagnosis submitted
- Reduced services*
- Adding CPT modifiers 22**, 53**, 54*, 55*; and HCPCS modifiers KX* and QW**
- Timely Filing Denials
- Reopening requests from providers who are currently receiving payment adjustments (reductions) as a result of the Electronic Prescribing (eRx), Electronic Health Record (EHR) and/or Physician Quality Reporting System (PQRS) Incentive Programs
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate (Exceptions: If the denial is for medical necessity, a redetermination with supporting documentation must be sent to the contractor.).

  Acceptable Duplicate Denial Example: *A provider received a duplicate denial for billing multiple chest x-rays for the same patient on same date of service with all appropriate modifiers. The provider should submit a Written Reopening Adjustment request form, identifying the claim denied in error as a duplicate. A Redetermination is not needed in the above scenario, because additional documentation is not needed*

* The change of information may result in an overpayment.
** Additional supporting documentation may be required with the written reopening request.

The following requests *cannot* be handled by Written Reopenings (not an all inclusive listing):

- Unprocessable Denials (Remark Code **MA-130**/Claims without appeal rights)
- Claims that have demand requests for refund
- Adding additional line items that were not already billed
- Requests to recoup money
- Patient's Name/HIC number changes
- Medical Unlikely Edit (MUE) denials, exceeding the MUE limit (Note: Must file a Redetermination with supporting documentation)

REDETERMINATIONS

The Redetermination is the first level of appeals. Medicare regulation states that a party who is dissatisfied with an initial determination may request a contractor review of such determination. Your redetermination request must include the reason you are requesting a review and must include documentation that supports your reason for requesting the redetermination.

myCGS Redeterminations

Redetermination requests are accepted through the myCGS web portal by completing the online Redetermination request form. Providers who are registered users may complete and submit the form. There is also an Appeals Time Limit Calculator to help ensure the request is timely.

The following information must be included on a Medicare Part B myCGS Redetermination:

Beneficiary Information:

- Patient's Name
- Patient's State
- Medicare HIC number
- Patient's Phone Number

Along with the completed Redetermination form, providers must attach at least one document to the request; no more than five. Attachments must be in a PDF format and up to 5MBs in size. Submission ID numbers are assigned to each case, which can be used to track the status of the Redetermination request.

To submit a request for Redetermination through myCGS, step-by-step instructions are available in the Part B provider section of Chapter 7 (http://www.cgsmedicare.com/pdf/myCGS/chapter7_partb.pdf) in the *myCGS User Manual*.

You may also submit your request on the **Medicare Part B Jurisdiction 15 Redetermination Form** (http://www.cgsmedicare.com/pdf/PartB_RedeterminationForm.pdf). This form is not required, but we recommend you use this form to help ensure that you have included all required information.

The Redetermination request must be sent to:

CGS
Attention: Redeterminations
PO Box 20018
Nashville, TN 37202

NOTE: CGS does not accept Redetermination requests via fax.

Redetermination requests must be submitted within 120 days from the initial claim determination. If a request is received after 120 days and a "good cause" can be found for late filing, please indicate the

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"good cause" reason on line 6 of the Redeterminations Request form. Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.

FIVE LEVELS OF APPEALS

First level of Appeals is a Redetermination

All Redeterminations are handled by qualified CGS employees that were not involved in the initial claim determination. Providers/ suppliers must submit a Redetermination within 120 days of the initial claim determination. A minimum monetary threshold is not required to request a Redetermination.

Second Level of Appeals is a Reconsideration

After the Redetermination process is completed a provider/ supplier has an option to submit a Reconsideration. All Reconsiderations are handled by a Qualified Independent Contractor (QIC). The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. Providers/ suppliers must submit a Redetermination within 180 days of receipt of the Redetermination decision. A minimum monetary threshold is not required to request a Reconsideration.

Third Level of Appeals is an Administrative Law Judge Hearing

After completing the Reconsideration process a provider/supplier has the option of requesting a Administrative Law Judge (ALJ) Hearing. A request for an ALJ hearing must be made within 60 days of receipt of the Reconsideration decision. Effective January 1, 2016, at lest $150 must remain in controversy following the QICs decision.

Fourth Level of Appeals is an Appeals Council Review

If a provider/ supplier is dissatisfied with the ALJ's decision an Appeal Council Review can be requested. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. There are no requirements regarding the amount of money in controversy.

Fifth Level of Appeals is a Judicial Review in U.S District Court

The final level of appeals consists of a judicial review before a US District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. For requests filed on or after January 1, 2016, $1,500 or more must still be in controversy following the Appeals Council's decision.

For additional information please visit, http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf.

WHEN TO USE A REDETERMINATION

- Ambulance denials. **Note: Run tickets should be included to support each trip.**
- Charges denied as Part A because the patient was seen in the office prior to admission in the hospital. **Note: Documentation should be included to support the office service.**
- Shared care denied for global service already on file. **Note: Documentation of the share care should be included to support the service billed.**
- Claim denied as not medically necessary and the provider has supporting documentation to support the medical necessity.
- Procedures denied for exceeding Medically Unlikely Edits. **Note: Documentation supporting medically reasonable and necessary units of service should be included with the request.**
- Claims adjusted causing an overpayment may be appealed with supporting documentation.

The above list is not an all inclusive list of when to submit an appeal.

RESOURCES

1. *Internet Only Manual, Publication 100-04, Chapter 34 – Reopening and Revision of Claim Determinations and Decisions* https://www.cms.gov/manuals/downloads/clm104c34.pdf
2. *Internet Only Manual Publication, Publication 100-04, Chapter 29 –Appeals of Claim Decisions* https://www.cms.gov/manuals/downloads/clm104c29.pdf

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